

## Transnational Migration, State Policy and Local Clinician Treatment of Asylum Seekers and Resettled Migrants

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# *Transnational Migration, State Policy and Local Clinician Treatment of Asylum Seekers and Resettled Migrants*

Comparative Perspectives on Reception Center and  
Community Health Care Practice in Finland

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**ABSTRACT** Based on interviews conducted at five Finnish reception centers and in two municipal communes during summer 2002 with 93 migrants, mainly from a variety of Southern and Eastern countries of origin, and their ethnoculturally discordant clinicians, the article compares asylum seekers and foreign-born residents in terms of health care treatment and outcome perspectives. Comparative analysis suggests that context makes a difference in post-migration medical encounters. The legally admitted foreign nationals consulted at community facilities were considerably more likely than were asylum seekers assisted at reception centers to be satisfied with the health care they had received and to be confident that the attending physician's recommendations would serve them well in the future. Policy implications related to the study's findings are explored. In Finland and elsewhere, the education of general practitioners for transnational medical encounters needs to be enhanced. International and national efforts to promote health also need to encompass political asylum and third country resettlement policies. In Finland and other migrant-receiving states, prolonged insecure immigration status can be debilitating for both asylum seeker and host society. Expedited admission to legal residence and expanded choice of physician are likely to result in improved health outcomes.

**KEYWORDS** *global health, immigration policy, migrant health, physician education, political asylum, transnational competence*

In today's increasingly borderless world, an unprecedented number of individuals and households are on the move. Global processes of travel, trade, privatization, ecological damage and displacement have undermined the capacity of nation-states to manage public health within their borders (Fidler, 2001: 263; Garrett, 2001: 185–8; Janes, 2002: 18–24; Kimball et al., 2004; Price-Smith, 2002: 4, 41–2, 164–6). The collapse of time and distance and the simultaneous retreat in state capacity to provide resident populations with essential services and protection (see Koehn and Rosenau, 2002: 105, 122) enable and encourage people to move around the world to a degree previously unimaginable. Now, roughly a billion people traverse nation-state borders annually (see Kovacs, 1999: 624; Rosenau, 2003: 64). An estimated 200m men, women and children – including officially recognized and de facto refugees, skilled professionals, students, contract workers, victims of human trafficking and undocumented residents – currently live outside their country of origin (Bollini and Siem, 1995; *Missoulian*, 2004b: A4; Stalker, 2001: 11; Tuladhar, 1999: 112). With the dismantling of formal barriers to labor mobility within the European Union, millions of Europeans currently work and reside in a member country other than their own (Conant, 2004: 313). Some participants in the contemporary global mobility upheaval, the trans-migrants, are constantly or periodically in motion back and forth across contiguous or non-contiguous territorial boundaries (Eastmond, 1998: 162, 172–3; Koehn and Rosenau, 2002: 117; Schiller, 1999). Looking toward the future, the most likely population scenario will involve 'more people, more population movements, more displacement – both internally and internationally – and more demands for effective responses by relevant authorities' (Helton, 2002: 14).

In a mobility-driven world, where mass screening, coercive quarantines and exclusion are no longer practicable or effective (Garrett, 2001: 186; Grondin et al., 2003: 88; Koehn, forthcoming), recent and projected increases in migrant populations pose daunting challenges for national and international health policy. From the perspective of the nation-state and the international health regime, the global health challenges that arise from the expanding volume, pace and duration of cross-border migrations include: (1) the transmission of emergent, population-threatening and economically and politically destabilizing infectious diseases (see Brower and Chalk, 2003; Fidler, 2003; Kickbusch, 2003; Martens, 2002: 642–3; *Missoulian*, 2004a: A12; *New York Times*, 2004: A12; Porter et al., 2002: 185–6); (2) unusual, resource-demanding presentations of chronic illness, injury and mental health needs; and (3) threats of bioterror. Today, instead of 'concentrating resources primarily on screening for communicable diseases' (Weinstein et al., 2000: 304), international agencies, non-governmental organizations (NGOs) and governments focus on health awareness, rapid responses and preventive actions, and strategies aimed at countering biological terrorism. In spite of the absence of epidemiological evidence that would support distinguishing them

from other types of migrants and transmigrants, however, government authorities continue to frame asylum seekers as disease carriers, and screening requirements for forced migrants have been slow to change (van Ewijk and Grifhorst, 1998: 247).

A substantial and growing body of evidence documents the inequities that prevail in access to primary health care, certain tests and medical procedures and personally satisfying treatment among dislocated and disadvantaged populations throughout the world (see Chen et al., 1999: 284–5, 287, 294; Cooper et al., 2003: 907; Gifford et al., 2002; Goode, 2001: A1, A12; Hall et al., 1988: 666–7; House and Williams, 2000: 81, 88, 91, 93; King, 2002: 1401; Maynard et al., 1986; Schulman et al., 1999; Smedley, 2003: 1, 5, 30, 77–9, 239; Stewart et al., 1999: 306; van Ryn and Burke, 2001; Waitzkin, 1985: 98; WHO and World Bank, 2002). The resulting disparities are rooted in individual behavior, social and institutional forces that operate at transnational, regional, national and local levels and in power differentials (Pappas, 1990). Although the reasons for disparities in health care access, testing, treatments and therapies, morbidity and mortality among persons who lack ‘voice’ in biomedical institutions are multiple and complex (see Roter and Hall, 1992: 46–9), the clinician–patient relationship constitutes an important contributing – and potentially mitigating – factor (see Cooper et al., 2003: 913; Elderkin-Thompson et al., 2001: 1344; Ferguson and Candib, 2002: 353–9; Goode, 2001: A1, A12; Jacobs et al., 2001; Morales et al., 1999: 413; Smedley et al., 2003). For refugees and other ethnoculturally different migrants, ‘the medical interview holds the potential to undermine inequalities or to reproduce them’ (Fox, 2000: 27). Furthermore, mutual clinician–patient satisfaction with the transnational medical encounter enhances prospects for the health-promoting social, economic and political incorporation of migrants and for gains that accrue to the global health commons (Chen et al., 1999: 294).

Individuals and families in transnational spatial transition frequently confront new health risks along with inequities in access and treatment (Smedley et al., 2003: 35; Stephen et al., 1994: 4). Concomitantly, the ethnically different care providers that migrants encounter in clinical settings find themselves challenged by a multiplicity of cultural, subcultural and mixed-origin beliefs and practices. When persons in the East or South who have been dislocated by global processes and/or local interventions reach Northern countries where professional medical workers are relatively homogeneous, prospects for ethnocultural provider–patient match are remote. In light of the unprecedented ‘movement and mixing’ of people who draw on diverse identities, therefore, global health is shaped increasingly by the multitude of individual and family approaches negotiated through interpersonal interactions among clinicians and users who meet in physical and mental health care settings where cultural and ethnic match is not an available option (see Fox, 2000: 29; Koehn, 2004: 70; Pachter, 2000: 36; Sue et al., 1991: 534, 539; Vega and Lopez, 2001: 196).

The social policy context of receiving countries merits attention as a factor shaping the post-migration response of states to dramatic increases in ethno-culturally discordant clinical encounters (also see Watters, 2001: 1716–17). Most governments have adopted differential treatment and acculturation/integration policies. In light of their reluctance to grant official long-term admission to all persons who enter their borders, state policy-makers prefer to address the health care needs of certain migrants in specially designated, separate facilities (camps, reception centers). Concomitantly, other migrants and transmigrants are granted access to the same public and community-based services available to natives. Do clinicians serving Northern reception centers treat asylum seekers differently than physicians and nurses treat migrants who have been legally admitted to residence? Do perspectives on health care outcomes differ among each patient group? There is growing recognition on the part of scholars that context – including site characteristics (see Cooper et al., 2003: 913) – plays a critical role in multicultural interactions (see Matinheikki-Kokko, 1997: 17) and that the distribution of health care resources is a reliable indicator of the presence/absence of social justice in state welfare systems (Janes, 2002: 2). Nevertheless, little is known about migrant perspectives on health care service in either reception centers or community-embedded facilities and we lack explicit comparative assessments.

The project findings reported in this article allow for policy-linked comparisons of Finnish reception center and community contexts in terms of selected treatment factors and migrants' health care outcomes. After describing the policies that shape opportunity structures and provider–patient interactions in each setting, the research procedure utilized and the study participants, the article compares clinician treatment in reception centers and community facilities along with asylum seeker and admitted-migrant perspectives on satisfaction with physician care and future confidence in biomedical approaches. The article concludes by considering the national and international policy implications of the study findings in comparative perspective.

### *State Policies Affecting Migrant Health Care in Finland*

As late as 1980, there were only some 13,000 foreign citizens living permanently in Finland (Wahlbeck, 1999: 75–7). By 1995, Finland had embraced migrants from more than 150 nations 'and a still greater diversity in terms of ethnicity, religion, language and culture' (Matinheikki-Kokko, 1997: 14). At the beginning of 2001, nearly 91,000 foreign nationals were living in Finland. They comprised about 1.7 percent of the country's population (EMCRX, 2001: 85; Korkiasaari, 2001). Individuals from the former Soviet Union, including Estonia, constituted the largest group of foreign nationals (roughly 35,000, or 38 percent of the total) (Korkiasaari, 2001). Half or more of this

group are Ingrian Finns, who are treated as 'returning migrants' under state policy (EMCRX, 2001: 85).<sup>1</sup> Another 20,000 Ingrian Finns are projected to return in the future (cited in Mannila, 2003: 2). Aside from Ingrian Finns, the largest groups of resident foreign nationals are persons of Swedish nationality (7922, or 8.7 percent; Korkiasaari, 2001) and those from Iraq/Iran/Turkey – mainly Kurds – (6829, or 7.5 percent of the total; see Wahlbeck, 1996: 9), the former Yugoslavia (5203, 5.7 percent), Somalia (4189, 4.6 percent)<sup>2</sup> and Vietnam (1816, 2 percent; see Liebkind, 1996: 166).

Many among the four latter groups are quota refugees admitted under annual agreements the government has reached with UNHCR since 1986 (756 persons in 2000), individuals granted political asylum or humanitarian protection from armed conflict or other threats, and persons entering as family reunification cases (see Kiuru, 2002: 9–10). By 1997, the government of Finland had granted residence permits to approximately 15,000 quota refugees and asylum applicants (Korkiasaari and Soderling, 1998: 16, 18; see also Wahlbeck, 1999: 56, 60, 78). The Finnish Red Cross assists quota refugees with local resettlement in the 134 municipal communes (out of about 460 total throughout Finland) that have been willing to contract with the state to accommodate refugees ([www.ifrc.org/publicat/partner/fiprofil.asp](http://www.ifrc.org/publicat/partner/fiprofil.asp)). Most opt to live in or near Finland's largest cities (Helsinki, Tampere and Turku). About 20,000 resident foreign nationals are temporary workers, students or their family members (Korkiasaari and Soderling, 1998: 18). An estimated 100,000 additional persons with a first language other than Finnish or Swedish, including some 15,000 spouses of Finnish citizens (Korkiasaari and Soderling, 1998: 18), have become Finnish citizens. They bring the total foreign-born population to just under 200,000 (Mannila, 2003: 2).

In 2002, Finland's 15 geographically dispersed 'open' reception centers could accommodate around 3000 political-asylum seekers. Municipal communes (local governments) operated reception centers in Helsinki, Kajaani, Kontiolahti, Kotka, Oravainen, Ruukki, Tampere, Vaasa and Punkalaidun. The state (central government) ran centers in Joutseno, Oulu and Pernio. The Red Cross (non-state actor) operated centers in Rovaniemi, Turku and Kemijarvi. Asylum seekers typically live in these centers for up to two (or even three) years while they await a decision on their application (see Alitolppa-Niitamo, 2000: 48; Wahlbeck, 1996: 10, 91). Most decisions are negative (Wahlbeck, 1999: 78). The appeal process can take several more years. Finnish authorities deport few rejected asylum seekers (see, for instance, Tuomarla, 1998: 292).

While the total number of refugees and asylum seekers in Finland is comparatively small by European standards, the country's entire population is only slightly more than 5m persons and the increase in foreign nationals who entered during the 1990s (five times the number present in 1987) exceeded that of any other EU state (Pitkanen and Kouki, 2002: 104–5). As Finland continues to move 'from the periphery of traditional migration routes into

the global arena of migration movement', these trends are likely to persist (Valtonen, 1998: 39).

In 2002, 3443 asylum seekers arrived in Finland (Nordberg, 2004: 719).<sup>3</sup> Political-asylum seekers who reach Finland are required to undergo a health check that includes a voluntary HIV/AIDS test. As long as their petition for resettlement has not been accepted, they are not entitled to a social insurance card. These policies are similar to those in effect in the Netherlands (see Drozdek et al., 2003: 203–4, 209). The health needs of asylum seekers are primarily attended to at their reception center by resident nurses and part-time physicians recruited from the public sector (commune primary health care center) or the private sector on a fee-for-service basis. When necessary, reception center nurses arrange for hospital treatment or specialist care (Verho, 2000: 4, 7).

Consistent with the Maastricht Treaty, the government issues quota refugees, 'remigrating' Ingrian Finns, accepted asylum seekers and spouses of Finnish citizens a social insurance card that entitles them to receive all health care and other social services on the same basis as Finnish citizens (Malin, 2000: 3; Matinheikki-Kokko, 1997: 13–14). In this egalitarian welfare state system (Wahlbeck, 1999: 64, 80), continuously resident foreign nationals typically participate in their commune's primary health care system on the same basis as other resident Finns do (Conant, 2004: 291; Tuomarila, 1998: 293). Finland's national health insurance system reimburses care seekers for only part of the costs of private treatment (Koivusalo, 2003: 170; Malin, 2000: 2). Thus, while all residents can opt to pay for (supplemental) private sector health care, few refugees or Ingrian Finns are in a position to afford it. This means that the general practitioner (GP) most resident foreign nationals consult with initially is assigned according to one's neighborhood of residence without regard to considerations of ethnic match, and that specialist or hospital care generally requires a GP's referral.<sup>4</sup> Given the decentralized nature of Finland's public health system,<sup>5</sup> moreover, differences in the provision and quality of health care are encountered from one commune and subdistrict to another (Malin, 2000: 2).

In 1997, Finland's official policy for accommodating quota refugees and asylum seekers granted residency changed from assimilation to *pluralism* – defined as allowing retention of the central, distinctive elements of one's culture while being granted the status of an equal member of Finnish society (see Matinheikki-Kokko, 1997: 51; Pitkanen and Kouki, 2002: 107). However, the Integration of Immigrants and Reception of Asylum Seekers Act of 1999 requires that accepted immigrants develop and pursue an individual 'integration plan' (encompassing in-country education, Finnish-language study and employment training) that will facilitate integration into Finnish society, or face restrictions on the social benefits they are eligible to receive from the state (Alitolppa-Niitamo, 2000: 51; Malin, 2000: 2; also see Pitkanen and Kouki, 2002: 106, 114). Moreover, Finnish authorities who possess

considerable discretion in implementing immigration and resettlement policies continue to prefer assimilationist practices (Matinheikki-Kokko, 1997: 57, 68; Pitkanen and Kouki, 2002: 112, 116; Wahlbeck, 1999: 81).

### *Study Procedure and Participants*

The comparative analysis presented here is based on data drawn from 118 interviews conducted during summer 2002 with adult political-asylum seekers and their Finnish physicians and nurses at five reception centers spread across the southern tier of Finland (Kontiolahti, Joutseno, Kotka, Turku and Helsinki) and from 117 interviews conducted with adult foreign-born residents who receive health care in two cities (Helsinki and Joensuu) and their principal clinicians. For the asylum seeker study, the researcher randomly selected study participants from nationality-based lists of current adult resettlement center residents who had clinically presented. Staff at each reception center prepared and enumerated each partially 'blind' list, provided each selected asylum seeker with a brief explanation of the study, and inquired about his or her willingness to participate. Their lists were 'blind' in that staff provided the researcher with the names of only those selected asylum seekers who had agreed to take part in the interview. In total, we conducted interviews with 41 asylum seekers – 10 from the Turku reception center, nine from Kontiolahti, eight from Joutseno and seven each from Helsinki and Kotka. The interviewed asylum seekers included 11 Kurds from Iran, Iraq and Turkey (31 percent of the total number of Kurdish adults residing at the five selected reception centers at the time of the study), 12 Albanians, mainly from Kosovo (30 percent), 13 asylum seekers from the former Soviet Union (18 percent) and three Somalis (60 percent). We also interviewed the only asylum seeker from Bosnia resident in one reception center and the only Angolan at another. Center staff reported only one Kurdish speaker and one Albanian who declined to be interviewed. Thirty-six of the selected asylum seekers had seen a doctor at the time of the study; all had seen a nurse. We identified and incorporated the patient's principal attending physician and support professional (nurse, social worker); we excluded any 'secondary' clinicians who had not consulted as frequently with the patient. Nine cases involved an attending physician who had also trained in psychotherapy/psychiatry. All of the primary physicians and nurses attending to asylum seekers agreed to participate in the study.

Since comprehensive public lists do not exist for the foreign-born population, 'simple random sampling was a non-starter' for the resident foreign national part of the study (Hughes et al., 1995: 189–90). The researcher used flexible sampling techniques to select legally resident migrants belonging to small, hard-to-reach ethnic groups who lived in the eastern town of Joensuu and in the Helsinki metropolitan area from blind lists



of adult members or patients constructed by commune medical or social work personnel, NGOs and community associations (also see McMunn et al., 1998: 454). For instance, physicians at the Herttoniemen subdistrict commune health center in Helsinki invited patients who arrived for appointments from mid-June through mid-July to participate in the study. Medical and social work officials in Rantakyla district in Joensuu prepared lists of Russian-speaking migrants and returning Finns that could be randomly sampled. From the affiliation list maintained by the Association of Nigerians in Finland, the organization's president assembled a convenient sample of 'available' members for interviews. The resident foreign national (RFN) group includes quota refugees and admitted asylum applicants, Ingrian Finns, foreign students who had acquired residency and the spouses of Finnish citizens or other legal residents; there are no tourists, short-term business persons or undocumented migrants in the sample. The final RFN sample consists of 21 adults treated in Helsinki commune health centers and 21 adults encountered in Joensuu commune health centers. Of the 10 remaining study participants (five resided in Helsinki and five in Joensuu), three had consulted their primary care provider at the Foreigners' Crisis Prevention Center, two at a private clinic and five at a specialized hospital clinic.<sup>6</sup> Four of these RFN cases involved interaction with a specialist (e.g. surgeon) and two cases involved a dentist.

Independent and privately conducted interviews, most of which ranged from 45 to 90 minutes in duration, utilized a structured, pilot-tested questionnaire designed to elicit basic social and demographic data and perspectives on patient and clinician health-related attitudes and behavior from the migrant, his or her doctor and his or her health-support professional (most commonly a nurse). Each study participant reported on perceived health outcomes (e.g. patient satisfaction with the results of the health care provided by the principal attending physician) using a uniform five-point Likert-type response scale. In all cases, interviewers secured prior verbal consent and promised study participants that their names would never be used, that information that might link them to specific responses would be destroyed, that the interviewer and the interpreter (if any) would respect their confidentiality and not divulge their responses and that all project data would be coded and only reported in a statistical and anonymous manner. The principal investigator explained to all migrant participants that their answers would have no affect on their access to services or on the outcome of their asylum application, described his general plan for disseminating project findings among participating migrant communities and Finnish health care professionals, and noted his intention to contribute to improving migrant health care generally through policy and training recommendations.

I conducted 13 face-to-face interviews with asylum seekers (32 percent of the total) in English. Fluent English-speaking interpreters interviewed nine reception center patients in Russian (22 percent), eight (20 percent) in a

Kurdish dialect (mostly Sorani and Kurmanji; see Wahlbeck, 1999: 40), six in Albanian (15 percent), two in Somali (5 percent), two in Turkish (5 percent) and one in German (2 percent). In the asylum seeker study, I conducted 29 of the physician interviews (81 percent) and all of the support professional interviews in English. Many of these respondents opted to follow along with a hard copy of the Finnish translation of the questionnaire. Project assistants conducted the seven other physician interviews in Finnish.

In the RFN study, I interviewed 22 migrants (42 percent of the total) in English. Fluent English-speaking interpreters completed 13 foreign national interviews in Russian (25 percent), seven in Finnish (14 percent), seven in Somali (14 percent) and one each in Kurdish/Sorani, Vietnamese and French. The selected RFN cases included five persons whose primary health care interaction occurred with a social worker, two with a trained social worker/psychologist, one with a physiotherapist and one with a dental assistant. Nurses served as the principal attending support professional in the remaining 21 cases. Among the identifiable and available clinicians, I conducted 13 of the attending physician interviews (40 percent) and 12 of the support professional interviews (40 percent) in English. Many of these respondents also followed along with the Finnish translation of the questionnaire. Project assistants completed the others (60 percent) in Finnish.

#### BACKGROUND COMPARISONS

The asylum seekers interviewed came from 13 different places of origin. Nearly one-quarter (10, or 24 percent of the total) named Kosovo as their homeland. Five (12 percent) came from Turkey. Four interviewees (10 percent) were from Iran and another four were from Ukraine. There were three (7 percent) each from Somalia, Russia and Chechnya. Two (5 percent) came from Iraq, two from Albania and two from Uzbekistan. The other three came from Armenia, Angola and Bosnia. The RFN interviewees reported 14 different places of origin. The largest group (22, or 42 percent of the total) came from Russia – including nine whose first language was Finnish, one Tatar speaker and 12 whose first language was Russian. Three of the native Russian speakers were returning Ingrian Finns whose parent(s) had not taught them Finnish as their first language (see Forsander, 1999: 60, 63, 67). The other original homelands were Somalia (11, or 21 percent), Nigeria (6, 12 percent) and Vietnam (3, or 6 percent). One RFN respondent each came from Iraq, Ukraine, Estonia, Sudan, Guinea, Sierra Leone, Croatia, Macedonia, Italy and Northern Ireland.

While none of the asylum seekers had been granted legal permanent residency in Finland, the RFN sample included 10 persons who had become Finnish citizens (19 percent), seven citizen spouses (14 percent), 16 returning Finns (31 percent), four non-Finnish returning-migrant spouses (8 percent), seven admitted quota refugees or asylum petitioners who had not (yet)

become citizens (14 percent) and four persons with refugee family reunion status (8 percent). The others (6 percent) held temporary legal residency.

Both recent arrivals and long-term residents are represented in the sample. However, the majority of asylum seekers (51 percent,  $N = 41$ ) had lived in Finland for one year or less, whereas 54 percent of the resident foreign nationals ( $N = 52$ ) had lived in Finland for eight years or longer. Certainly, some admitted migrants who had adapted poorly to life in Finland, and some who had adapted well, had moved on to another country (or other countries) by the time of this study. It is not possible to determine the net effect of re-emigration on the adaptive abilities of the pool of remaining resident foreign nationals, however. What is known is that 198,172 persons, including native Finns, emigrated between 1981 and 2002 and that Finland experienced an overall net in-migration of 103,139 persons during this period (Finland, Institute of Migration, 2003a).

#### PERSONAL ATTRIBUTE COMPARISONS

The majority (58.5 percent) of the asylum seekers interviewed and slightly fewer than half (48.1 percent) of the RFN patients were male. Female physicians attended to 89 percent of the asylum seekers and 69 percent of the resident foreign nationals. Female nurses worked with 81 percent of the resettlement petitioners and 100 percent of the others. All of the reception center doctors and support professionals were Finnish. Although foreign-born doctors treated five of the cases selected at one commune health center in Helsinki, there were no ethnic/nationality matches among care providers and receivers in the entire sample.

The vast majority of asylum seekers (88 percent) were 40 years of age or younger in 2002. They included 11 study participants in the 18–25 age group (26.8 percent), nine between 26 and 30 (22 percent) and eight (19.5 percent) in both the 31–35 and the 36–40 groups. The resident migrants sampled were considerably older than the resettlement petitioners. Only 15 percent were between 18 and 25 years of age and 10 percent between 26 and 30. Roughly one-quarter of the RFN sample were between 41 and 55 in 2002 and about one-fifth were between 65 and 83.

#### MEDICAL ENCOUNTER COMPARISONS

The data presented in Table 1, which are based on available health center records, show that the sample includes a mix of asylum seekers who have been served by center medical personnel for less than eight months, nine to 13 months, 16 to 25 months and 29 months to four years. As expected, the RFN sample includes a sizeable number of individuals (17, or 44 percent of the total) who have been served by their current health care venue for more than four years. Another 23 percent have been in contact for 29–48 months. The sample also included eight foreign residents (21 percent of the total) who had less than eight months of contact with their primary health care venue.

TABLE 1 *Length of contact with health care venue in months: by type of study participant*

<i>Length of contact (months)</i>	<i>Asylum seekers (N = 41)</i>		<i>Resident foreign nationals (N = 39)</i>		<i>Total (N = 80)</i>	
	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>
7 or less	9	22.0	8	20.5	17	21.3
9–13	11	26.8	3	7.7	14	17.5
16–25	11	26.8	2	5.1	13	16.3
29–48	9	22.0	9	23.1	18	22.5
50–138	1	2.4	17	43.6	18	22.5

TABLE 2 *Number of consultations with principal physician: by type of study participant*

<i>No. of consultations</i>	<i>Asylum seekers (N = 35)</i>		<i>Resident foreign nationals (N = 48)</i>		<i>Total (N = 83)</i>	
	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>
only one	8	22.9	11	22.9	19	22.9
2–3	10	28.6	16	33.3	26	31.3
4–8	11	31.4	10	20.8	21	25.3
10–30	6	17.1	11	22.9	17	20.5

TABLE 3 *Number of consultations with principal health-support professional: by type of study participant*

<i>No. of consultations</i>	<i>Asylum seekers (N = 35)</i>		<i>Resident foreign nationals (N = 48)</i>		<i>Total (N = 83)</i>	
	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>
only one	3	7.3	3	9.1	6	8.1
2–3	6	14.6	6	18.2	12	16.2
4–9	13	31.7	7	21.2	20	27.0
10–17	16	39.0	6	18.2	22	29.7
20–80	3	7.3	11	33.3	14	18.9

While there are sizeable differences in the duration of the sampled asylum seekers' and resident foreign nationals' contact with the primary health care venue, the distribution is relatively even in terms of number of consultations with the principal attending physician (Table 2). In fact, asylum seekers were slightly more likely than resident foreign nationals to have met with their (current) primary physician on four or more occasions (49 percent vs 43 percent).

Migrants receive health care and advice more frequently from nurses than they do from physicians. In this study, foreign-born residents were more likely than asylum seekers were to have met with their primary health-support

TABLE 4 *Most common reasons reported by attending physician for medical encounters with asylum seekers and resident foreign nationals*

<i>Asylum seekers (N = 38)<sup>a</sup></i>	<i>Resident foreign nationals (N = 33)<sup>b</sup></i>
Mental health problem (16) (PTSD, depression, anxiety disorder, etc.)	Leg, knee, back, hand, neck, head pain/injury (11)
Leg, knee, back, hand, neck, head pain/ injury (16)	Stomach pain (6)
Gynecological problem (6)	Diabetes (4)
Flu (4)	High blood pressure (3)
Skin problem/rash (4)	Mental health problem – depression (3)
	Respiratory infection (3)

Notes:

<sup>a</sup> Four or more mentions.

<sup>b</sup> Three or more mentions.

professional (nurse or social worker) on 20 or more occasions (33 percent and 7 percent, respectively). Nevertheless, data presented in Table 3 indicate that over 70 percent of the asylum applicants had consulted with their nurse or social worker between four and 17 times at the point of their interview.

According to the attending clinicians, non-life-threatening non-infectious illnesses and/or injuries provided the *principal* reason for the clinical encounter(s) in the majority of the asylum seeker (50 percent;  $N = 40$ ) and RFN cases (57 percent;  $N = 37$ ). They primarily consulted regarding non-life-threatening infectious diseases with another 10 percent of the resettlement seekers and 8 percent of the admitted migrants. Even though some European authorities frame asylum seekers as a high-risk group for dangerous communicable diseases (see van Ewijk and Grifhorst, 1998: 247), only one sampled resettlement seeker case involved a life-threatening infectious disease (also see Grondin et al., 2003: 90). Asylum seekers were more likely than resident foreign nationals to be involved in principal clinical encounters that concerned post-traumatic stress disorder (10 percent vs 0 percent) or another mental health problem (23 percent vs 14 percent). Other principal reasons for the medical encounter in the RFN cases were antenatal care or mothers bringing in a child (8 percent), physical examination (8 percent) or immunization (3 percent). Two of the resettlement applicants (5 percent) had also only met with their physician for a physical examination.

In addition to classifying their principal type of interaction(s) with each selected patient, physicians listed up to three specific reasons (based on their medical records) for the encounters included in this study. Table 4 presents the results of the attending clinician's reports on the most common medical issues presented by the two types of migrant patients. Although the number of patients in each category is nearly the same, physicians attending to asylum seekers were much more likely to report that their encounters involved mental health problems than were physicians attending to resident foreign

nationals. In most other respects, the transnational encounters studied with both types of migrants encompass a familiar range of temporary and chronic conditions.

#### PATIENTS' PREPARATION FOR TRANSNATIONAL MEDICAL ENCOUNTERS

The migrant patients sampled can also be evaluated in terms of their preparation for interactions with Finnish clinicians. The first finding in this respect is that the vast majority of study participants had never received formal or informal advice regarding what to expect or how to act in medical encounters with Finnish clinicians. While about one-third of the asylum seekers (35 percent) reported that they had received at least some helpful advice (from any source) about how to behave with health care providers in Finland, only one in five resident foreign nationals (19 percent) recalled ever receiving such advice.

Another useful basis for evaluating preparedness for multinational clinical encounters focuses on interpersonal transnational competence (TC). The TC framework calls for a comprehensive and patient-informed perspective on multiple-culture and subcultural consultations, as opposed to a standardized and formulaic approach to two-culture interactions. Overall, TC encompasses five separate, but interrelated, skill domains (see Koehn, 2004; Koehn and Rosenau, 2002). This study assessed the five dimensions of TC intersubjectively. The data analysis procedure for scoring participant TC involved combining the separate case-specific subjective behavioral evaluations received from the migrant patient (see Kaplan et al., 1995: 1186) and the other medical encounter participants (principal doctor and/or support professional). Each study participant's overall TC evaluation is based on his or her composite mean score for analytic (five items), emotional (six items), creative/innovative (five items), communicative (seven items) and functional (eight items) skills.<sup>7</sup> Each respondent rated possession and demonstration of skill measures by her- or himself and the other team member(s) using a uniform three-point response set: 'yes'/always (coded or, in the case of negatively worded items, reverse coded as '1'); 'partly'/sometimes (coded as '2'); or 'no'/never (coded or reverse coded as '3'). We first calculated the study participant's mean score for each skill domain.<sup>8</sup> Lower scores indicate higher TC evaluations. Then, based on the mean score for all five skill domains, the researcher assigned each encounter participant, as well as the team as a whole (physician, support professional and patient), a score for overall TC for each case-specific set of interactions. Study participants with a mean score of 1.19–1.50 on the scale of 1 to 3 are judged to be highly competent, from 1.51 to 1.70 to be somewhat competent, and from 1.71 to 2.27 to possess relatively little competence.<sup>9</sup>

The findings reported in Table 5 indicate that there are great variations in the competence of the sampled migrants as a whole in terms of the five TC

TABLE 5 *Transnational competence assessments by skill domain: asylum seeker (ASY) and resident foreign national (RFN) comparisons*

<i>TC skill domain</i>	<i>Highly competent (%)</i>	<i>Somewhat competent (%)</i>	<i>Relatively little competence (%)</i>
ASY Analytic ( <i>N</i> = 41)	46.3	24.4	29.3
RFN Analytic ( <i>N</i> = 35)	62.9	22.9	14.3
ASY Emotional ( <i>N</i> = 38)	60.5	28.9	10.5
RFN Emotional ( <i>N</i> = 34)	82.4	14.7	2.9
ASY Innovative ( <i>N</i> = 41)	19.5	24.4	56.1
RFN Innovative ( <i>N</i> = 34)	23.5	26.5	50.0
ASY Communicative ( <i>N</i> = 41)	63.4	19.5	17.1
RFN Communicative ( <i>N</i> = 34)	76.5	11.8	11.8
ASY Functional ( <i>N</i> = 40)	15.0	20.0	65.0
RFN Functional ( <i>N</i> = 29)	13.8	27.6	58.6

skill domains. In general, both asylum seekers and admitted residents are judged to be highly competent in three domains (analytic, emotional and communicative), but to possess relatively little competence in two areas (innovative and functional). Across all five skill domains, those awaiting a decision on their application for admission are more likely than the legal residents to receive ‘relatively little competence’ intersubjective ratings and, with the exception of functional competence, the resident foreign nationals are more likely than the asylum seekers are to be judged ‘highly competent’.

#### MAINSTREAM INCORPORATION COMPARISONS

Given that most resident foreign nationals in this study have lived in Finland longer than most asylum seekers have, reside among Finnish nationals rather than at reception centers,<sup>10</sup> possess secure immigration status and lack developed ethnic enclaves (Forsander, 1999: 68–9),<sup>11</sup> one would expect them to manifest higher levels of incorporation into mainstream Finnish society in comparison with that reported by reception center residents. Several indicators of mainstream incorporation are available from the interview data. They include Finnish-language ability, primary language spoken at home and in medical encounters, and friendship patterns.

The interview findings with respect to language ability and usage clearly support the expectation of higher mainstream incorporation among resident foreign nationals. Nearly three-quarters (73 percent) of the resident foreign nationals reported that they speak Finnish adequately and 21 percent indicated that they possess some ability in the host society language (*N* = 52). Only 20 percent of the asylum seekers speak Finnish adequately and 29 percent speak no Finnish at all (*N* = 41). Moreover, 23 percent of the resident foreign nationals indicated that they most often spoke Finnish at home;

another 19 percent primarily used English, a language that is widely understood in Finland. The other resident foreign nationals mainly used Russian (25 percent), Somali (17 percent), Vietnamese (6 percent) or another language at home. In contrast, only 15 percent of the applicants for residency primarily spoke Finnish or English in the context of their household. Furthermore, 68 percent of the resident foreign nationals primarily used Finnish in their current health care encounters vs only 15 percent of the asylum seekers. Another 17 percent of the RFN sample and 12 percent of the asylum petitioners primarily used English in their medical consultations. The others relied on their first language (usually requiring interpreters) or Russian.

Friendship ties offer powerful indicators of encapsulation and acculturation (see Ying, 1995: 901, 906). It is interesting in this connection that virtually the same percentage of respondents from the two groups (50 percent of the asylum seekers and 52 percent of the legal residents) indicated that fewer than half of their (five) closest friends had a nationality other than their own. Nevertheless, a higher percentage of the resident foreign nationals than the resettlement petitioners listed a Finnish person among their five closest friends (42 percent vs 28 percent; see also Wahlbeck, 1999: 136–7).

### *Clinician Treatment in Reception Centers and Community Facilities*

This section compares the treatment context offered to the sampled asylum seekers at Finnish reception centers with that provided to the resident foreign nationals at commune health centers and other community facilities. Specifically, we compare attending clinician attitudes and preparation for multicultural encounters in the two settings, the TC possessed by attending physicians and support professionals, and the presence/absence of certain culturally appropriate services. Taken together, these factors tell us a great deal about the micro-structural context of migrant health care in Finland.

#### CLINICIAN ATTITUDES

Other researchers have observed the presence of admitted and hidden racist perspectives toward most of the nationality groups included in this study among a minority of Finnish health care workers (Pitkanen and Kouki, 2002: 115; Talvela, 1999: 72). On the other hand, none of the Kurdish refugees interviewed in Finland by Wahlbeck (1999: 100, 133) ‘felt that they had been discriminated against by the authorities in the area of social services and benefits’. In this study, I looked at clinician attitudes toward the statement ‘the health of [name of migrant patient] is not as important as the health of a native Finn’. All of the responding health care practitioners disagreed with the statement. However, subtle differences in the responses merit attention. Physicians attending to 88 percent of the legal residents *strongly* disagreed that



their patient's health was not as important as the health of a native Finn. However, physicians consulting with only 77 percent of the asylum applicants *strongly* disagreed with the statement. The differences in support professional attitudes are even more striking. In this case, those attending to 90 percent of the foreign-born residents *strongly* disagreed with the statement whereas nurses working with only 59 percent of the asylum petitioners *strongly* disagreed.

#### PRACTITIONER INTERCULTURAL PREPARATION

In addition to attitudes toward the patient, the clinical treatment of migrants is also influenced by the pre-encounter preparation of attending practitioners. Three dimensions of preparation for the types of transnational encounters under study are considered here: ability to speak the patient's first language and the formal training and informal intercultural exposure of attending clinicians.

Of all the first languages (other than Finnish and English) spoken by the migrants in this study, at least some of the attending clinicians were able to use one (Russian). The distribution of Russian-language ability among the practitioners sampled favored Russian-speaking asylum applicants. The attending physician could speak Russian in 43 percent of the encounters with Russian-speaking asylum seekers vs only 12 percent of the consultations with resident foreign nationals. The support professional possessed facility in the Russian language in 20 percent of the asylum applicant cases and in only 7 percent of the others.

The attending physicians were more likely than the attending health-support professionals to report that they had *never* received any formal training regarding how to offer culturally sensitive health care (54 percent and 20 percent of the cases, respectively; also see Talvela, 1999: 72). However, physicians attending to asylum seekers were more likely than were those who consulted with admitted residents to have received at least some intercultural training (54 percent vs 38 percent,  $N = 35$ ,  $N = 34$ ) while the opposite situation prevailed among support professionals (83 percent of those attending to legal residents reported extensive or partial training vs 78 percent of the others,  $N = 41$ ,  $N = 30$ ).

The final dimension of clinician preparation considered here is informal exposure to different cultures. Health care practitioners who choose close friends with ethnic backgrounds that differ from their own are likely to be better prepared in terms of values, perceptions and judgments for transnational medical encounters than are those whose friendship experiences are more limited (Bobo et al., 1991: 247; also see Pitkanen and Kouki, 2002: 110). The comparative analysis of friendship patterns suggests limited and mixed possibilities in terms of clinician intercultural preparation. In only six cases, all involving resident foreign nationals, did the attending physician report that half or more of his or her five closest friends belonged to a different

TABLE 6 *Transnational competence assessments by skill domain: comparisons of physicians (DR) and support professionals (SP) attending to asylum seekers (ASY) and to resident foreign nationals (RFN)*

<i>TC skill domain</i>	<i>Highly competent (%)</i>	<i>Somewhat competent (%)</i>	<i>Relatively little competence (%)</i>
DRASY Analytic ( <i>N</i> = 35)	40.0	31.4	28.6
DRRFN Analytic ( <i>N</i> = 31)	16.1	35.5	48.4
SPASY Analytic ( <i>N</i> = 41)	53.7	17.1	29.3
SPRFN Analytic ( <i>N</i> = 24)	41.7	20.8	37.5
DRASY Emotional ( <i>N</i> = 35)	22.9	28.6	48.6
DRRFN Emotional ( <i>N</i> = 29)	31.0	27.6	41.4
SPASY Emotional ( <i>N</i> = 40)	40.0	35.0	25.0
SPRFN Emotional ( <i>N</i> = 23)	47.8	30.4	21.7
DRASY Innovative ( <i>N</i> = 35)	8.6	34.3	57.1
DRRFN Innovative ( <i>N</i> = 28)	3.6	7.1	89.3
SPASY Innovative ( <i>N</i> = 39)	35.9	28.2	35.9
SPRFN Innovative ( <i>N</i> = 22)	40.9	13.6	45.5
DRASY Communicative ( <i>N</i> = 35)	37.1	25.7	37.1
DRRFN Communicative ( <i>N</i> = 30)	30.0	26.7	43.3
SPASY Communicative ( <i>N</i> = 41)	39.0	46.3	14.6
SPRFN Communicative ( <i>N</i> = 22)	50.0	40.9	9.1
DRASY Functional ( <i>N</i> = 35)	28.6	34.3	37.1
DRRFN Functional ( <i>N</i> = 30)	23.3	30.0	46.7
SPASY Functional ( <i>N</i> = 37)	59.5	21.6	18.9
SPRFN Functional ( <i>N</i> = 22)	81.8	18.2	0.0

nationality. On the other hand, only two of the support professional encounters with resident foreign nationals involved practitioners who possessed extensive other-nationality friendships (7 percent, *N* = 30), while nurses with considerable intercultural friendship experience attended to 10 of the asylum seekers sampled (24 percent, *N* = 41).

#### CLINICIAN TRANSNATIONAL COMPETENCE SKILLS

In this section, I compare the TC skills possessed by ethnoculturally discordant clinicians attending to the two groups of migrants using the same intersubjective assessment procedures and categories described earlier for migrant TC.<sup>12</sup> Table 6 shows that a larger percentage of the Finnish support professionals consulting with both asylum applicants and legal residents are highly competent across all TC skill domains in comparison with physicians. For innovative and functional competence,<sup>13</sup> the differences are considerable.

The findings presented in Table 6 also reveal that, with the exception of emotional competence, the physicians who treated asylum seekers were more likely than were those who treated resident foreign nationals to be highly

competent and were less likely to possess little competence. The differences among attending doctors are especially pronounced with respect to the analytic skill domain. In contrast, Finnish health-support professionals who interacted with resident foreign nationals were more likely than were those consulting with asylum seekers to be judged highly competent in all skill domains except analytic. The perceived strengths of nurses and social workers encountered outside of the reception center context are especially pronounced with regard to functional skills.

#### USE OF SELECTED CULTURE-SENSITIVE APPROACHES

Our final set of clinical treatment considerations concerns the presence or absence of culturally appropriate health care services (see Leong and Lau, 2001: 209). Four culture-sensitive interventions are explored here. They are (1) the provision of health education materials written in the patient's first language; (2) the provision of health care materials specific to the migrant's place-of-origin culture; (3) consultations with published reports, databases, internet resources (such as the EthnoMed website that provides access to an electronic database of culture-specific health care information pertaining to Somalis and other ethnic groups; Graham, 2000: 99, 106), or persons familiar with the patient's culture (regarding how to interact with him or her); and (4) consultations with and/or recruitment of support from a family member or a diasporic-community member regarding the patient's health/illness situation (Adler, 2002: 878).

Attending physicians were more likely to provide legal residents with materials written in their first language than were physicians consulting with asylum seekers (20 percent and 3 percent, respectively). However, support professionals provided such materials in a higher percentage of the asylum seeker cases (42 percent vs 29 percent for the RFNs).<sup>14</sup> The clinicians we interviewed admitted that they issued culturally specific materials to none of the sampled resettlement seekers and to only three of the legally admitted migrants.

Nearly two-thirds (63 percent,  $N = 64$ ) of the attending physicians had *not* conducted any background research into culturally appropriate ways to interact with the patient. Those that had were more likely to conduct such research in cases involving asylum seekers (47 percent) than they were in encounters with admitted migrants (27 percent). In contrast, 62 percent of the attending health-support professionals ( $N = 68$ ) indicated that they had consulted published reports, databases, internet resources or persons familiar with the patient's culture regarding how to interact with him or her. The differences in support professionals' research undertakings for asylum applicants and resident foreign nationals were negligible (60 percent and 64 percent, respectively).

In general, the doctors interviewed failed to consult with a family member or a diasporic-community member regarding the sampled patients' health/

illness situation (69 percent,  $N = 64$ ). They were somewhat more likely to engage in such consultations when the patient was a resident foreign national (37 percent of the cases) than when the patient was an asylum seeker (26 percent). Attending health-support professionals engaged in family/community member consultations more frequently (43 percent of all available cases,  $N = 68$ ). Support professionals also proved much more likely to undertake such consultations in cases involving RFN patients than they did in asylum seeker cases (59 percent vs 32 percent; with 41 percent vs 5 percent reporting 'extensive' consultations as opposed to partial ones).

### *Asylum Seeker and Resident Foreign National Health Care Outcomes: Southern and Eastern Voices*

Researchers have discovered that patients' own perspectives are particularly useful in assessing health care outcomes (see Bell et al., 2002: 823; Hunter, 1991: xx, xxii, 14, 63; Matinheikki-Kokko, 1997: 17–18). Ware et al. (1995: 539, 555) also report that 'patients are a particularly good source of information on the interpersonal aspects of the provider/patient relationship'. Stewart et al. (1999: 331) challenge us 'to incorporate patient perspectives in meaningful ways that lead to improvements in the health care quality and health status of all populations, especially those at higher risk of poor outcomes'. This section compares the perspectives of asylum seekers and legal residents with respect to two health care quality outcome measures: satisfaction and future confidence. Here, we are interested in the presence or absence of differences in outcome perspectives among migrants who encountered clinicians in reception center and community facility contexts.

#### SATISFACTION

Patient satisfaction is a cogent health care quality outcome consideration. Perspectives on satisfaction are subjective compatibility assessments of personal consultation experiences vis-a-vis health expectations and goals (see Valtonen, 1998: 42). Table 7 shows that there are striking differences between the two groups of migrants in perceived satisfaction with the health care they received from the attending physician. The asylum applicants we interviewed were much more likely than the admitted foreign nationals *not* to be (very) satisfied with the medical care they had received from the attending physician. While more than half (54 percent) of the asylum seekers were not satisfied, less than one in five (19 percent) of the resident foreign nationals indicated that they were not satisfied and nearly half (48 percent) were *very* satisfied. In a number of interviews, however, admitted migrants volunteered their dissatisfaction with one or more of the physicians whom they had encountered in the Finnish medical system prior to their current principal care provider. In addition, when medical interviews occurred primarily in

TABLE 7 *Patient's satisfaction/dissatisfaction with primary attending physician's care: asylum seeker/resident foreign national comparisons*

<i>Level of satisfaction/ dissatisfaction</i>	<i>Asylum seekers (N = 41)</i>		<i>Resident foreign nationals (N = 52)</i>	
	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>
Very satisfied	6	14.6	25	48.1
Satisfied	13	31.7	17	32.7
Neither satis./dissatis.	11	26.8	6	11.5
Dissatisfied	7	17.1	3	5.8
Very dissatisfied	4	9.8	1	1.9

TABLE 8 *Patient's future confidence in attending physician's biomedical health care recommendations: asylum seeker/resident foreign national comparisons*

<i>Level of confidence</i>	<i>Asylum seekers (N = 41)</i>		<i>Resident foreign nationals (N = 51)</i>	
	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>
Very confident	4	9.8	20	39.2
Confident	15	36.6	18	35.3
Neither confident/ not confident	10	24.4	8	15.7
Not confident	8	19.5	4	7.8
Very unconfident	4	9.8	1	2.0

Finnish, English or a combination of Finnish and English (including a third language), patient satisfaction ratings were also considerably higher than when the migrant's first language or Russian served as the primary vehicle for communication (73 percent vs 52 percent, respectively;  $N = 60$ ,  $N = 33$ ).

#### FUTURE CONFIDENCE

The findings presented in Table 8 also reveal substantial differences between the two groups studied in terms of confidence that the attending doctor's health care recommendations will be helpful for one's health over the next year or so. While three-quarters of the resident foreign nationals expressed confidence in their physician's recommendations, less than half (46 percent) of the asylum seekers were (very) confident that their attending doctor's recommendations would be helpful over the next year or so. In addition, resident foreign nationals were four times more likely than the resettlement petitioners to be *very* confident in their physician's recommendations. When clinicians were able to consult with patients primarily in Finnish, English or a combination of Finnish and English (including a third language), future confidence ratings in the primary physician's recommendations also were higher than when the migrant's first language or Russian served as the primary vehicle for communication (68 percent vs 52 percent, respectively;  $N = 59$ ,  $N = 33$ ).

## *Discussion*

The micro-structural context findings from this exploratory study reveal a number of cross-venue problem areas in the treatment of the migrants sampled in Finland. Clinicians provided migrants with materials printed in their first language in a minority of the cases examined and made available virtually no culturally specific materials. Researchers have noted a similar deficiency in the provision of culturally appropriate health education materials to asylum seekers in the Netherlands (van Ewijk and Grifhorst, 1998: 248). In addition, few of the attending clinicians were able to converse with resident foreign nationals or asylum seekers in the patient's first language. Potentially, aspects of communicative TC, such as the ability to use an interpreter effectively (see Graham, 2000: 106; Koehn, 2004: 76), could compensate for this limitation in provider-patient consultations. Interpreter services are provided by the state in Finland and are generally well organized (Wahlbeck, 1999: 97). However, with the exception of support professional interactions with resident foreign nationals, fewer than 40 percent of the attending clinicians scored high on communicative competence. Furthermore, physicians failed to conduct background research regarding how to offer health care in the migrant's culture in greater than 60 percent of all cases studied and failed to consult with the patient's family and/or a community member in 69 percent of all cases. Health support professionals failed to consult with a family/community member in 68 percent of the asylum seeker cases.

Transnational analytic, emotional, creative, communicative and functional skills can be valuable in treating patients from diverse national backgrounds who present with familiar and minor as well as unexpected and acute health care needs. However, 60 percent or more of the cases sampled for both resident foreign nationals and asylum seekers involved treatment by physicians not judged to possess high TC across all five skill domains. Moreover, the interviewed doctors and health support professionals reported limited and inadequate exposure to formal training in culturally sensitive health care and even less exposure to opportunities to build intercultural interaction skills through informal (close friendship) experience.

We also discovered important differences in the selected treatment factors between asylum seekers at the five reception centers and foreign nationals resident in the two Finnish cities. Most critically, clinicians who did not strongly disagree with the statement that 'the health of [name of migrant patient] is not as important as the health of a native Finn' were more likely to treat asylum seekers than resident foreign nationals. In comparison with asylum applicants attended to at the five reception centers, the legal residents encountered at community health care facilities were more likely to be treated by a physician or support professional who had consulted with a member of their family or ethnic community regarding their health/illness situation. However, resident foreign nationals were less likely to be treated by

physicians who had conducted background research regarding culturally appropriate ways to interact with them. Such neglect could contribute to the finding reported in US-based studies that the health of immigrants tends to decline with increased duration of residence in a new environment characterized by increased exposure to stress and health-adverse behaviors (see Bernstein, 2004: A27; Gordon, 2004: 12–13; Stephen et al., 1994: 4–5).

The principal finding of this study is that immigration status plays a role in shaping perceptions of post-migration health outcomes. First and foremost, 15 (56 percent) of the 27 interviewed asylum seekers who reported experiencing mental health problems in Finland believed that being admitted to legal residence in Finland was the factor that would ‘most improve’ their mental health in the future. In addition, legally resident foreign nationals consulted at community facilities were considerably more likely than were migrants with undetermined immigration status assisted at reception centers to be satisfied with the health care they had received and to be confident that the attending physician’s recommendations would serve them well in the future.<sup>15</sup> These outcomes might reflect the opportunities that are available to resident foreign nationals, even in a neighborhood-assigned system, to select one’s principal physician and to exit from unsatisfactory physician encounters (Hjortdahl and Laerum, 1992: 1289). In reception centers, by contrast, most asylum seekers have no choice in their attending GP. Other researchers have found that ‘patients unable to choose their physician may be less satisfied with their care and perceive quality of care to be lower’ (Mainous et al., 2001: 23; Schmitt diel et al., 1997: 1598).

The main limitations of this study are associated with its exploratory nature. The small number of study participants and the non-randomized sampling procedures used in selecting resident foreign nationals restrict the statistical power of data analysis. Results might differ in other migrant-receiving countries, in refugee camps and among resident foreign nationals treated at rural health centers. The cross-sectional nature of the study constitutes another limitation. While clinicians possessed records to refer to, some patients were expected to recall medical consultations that took place a year or more prior to the interview.

Further research is needed that will address the principal limitations of this exploratory study. Ideally, future research will involve a large sample of (trans)migrant patients, will be longitudinal and cross-national in design, will be successful in interviewing a more representative sample of resident foreign nationals – including tourists and other short-term visitors – and will include a longitudinal control group of ethnoculturally concordant patients/clinicians. The contextual findings of this study also suggest the utility of including assessments of the medical encounters that resident foreign nationals experience with clinicians who are no longer their principal care provider even though the challenges involved in identifying, locating and interviewing such study participants would greatly complicate the research task.

### *Policy Implications*

The national and international policy implications of this study's principal findings can be addressed at both patient-encounter and structural levels. The evidence presented here suggests that in Finland, as in other Northern states, physicians (as well as nurses to a lesser extent) lack key skills in treating patients with ethnocultural backgrounds that differ from their own. Medical education has been insufficient and deficient. A new curriculum that prepares all clinicians for diverse transnational encounters is needed in this age of population mobility. Based on findings reported here and elsewhere, a contemporary medical school curriculum would usefully embrace the following features:

- Prepare doctors and nurses for multicultural, subcultural, mixed-origin and transnational encounters rather than be limited to particular bicultural encounters.
- Rely on the individual patient as teacher, as the fluid starting point for discovery, rather than on memorization of formulaic lists of culture-specific characteristics (Betancourt, 2003: 562–3; Culhane-Pera et al., 1997: 723; Shapiro and Lenahan, 1996: 249–50; Smedley et al., 2003: 207).
- Focus on the global and local structural foundations, the proximate and distant sources, of health-shaping inequities (Wear, 2003: 551–2).
- Explore the impact of dislocation experiences, 'unfinished endings' (Lipson and Meleis, 1999: 89), current immigration/transmigration status and the presence/absence of social networks and patient power (see Cowen, 1991: 407; Valtonen, 1998: 57).
- Ensure that the comprehensive core of necessary transnational interaction skills is integrated across preclinical and clinical learning experiences and is reinforced longitudinally.
- Emphasize problem-solving approaches that identify assets and resources amid liabilities and vulnerabilities (Ager, 1999: 13; McPhatter, 1997: 269) and involve the patient and his or her family or community members in health maintenance and promotion (Valtonen, 1994: 75–7).
- Help students identify and negotiate complementary and creative combinations of biomedical and ethnocultural/personal health care beliefs and practices that are neither clinically nor culturally contraindicated.
- Encourage students to develop and demonstrate skills in formulating and securing institutional and community support for enabling approaches that take into consideration the effects of social context, including immigration status, on migrant health (Gerrish et al., 1996: 137–8).
- Prepare clinicians for advocacy on behalf of migrant patients with social service agencies and with local, national and international authorities that shape law and policy (see, for instance, Alegria et al., 2003).



In short, a far-sighted medical school curriculum would move beyond cultural competence into transnational competence. This insight applies not only to Finland, but across migrant-receiving countries. In 2005, for instance, three US medical schools initiated the process of introducing a TC curriculum by piloting changes in third-year clerkships that are aimed at enhancing students' transnational analytic, emotional and functional competence (Swick and Koehn, 2005).

At the structural level, the expansion and variability of transnational clinical encounters presents daunting challenges for state policy and for health care providers. When public authorities, international organizations and NGOs respond to the forces of globalization that generate local health equity and social justice issues (see Janes, 2002), the context of their response makes a difference. The present study focused on one dimension of the socio-political context of migrant health care: the presence/absence of legal residency status. Previous research has found that being granted legal residency status enhances personal/family security, economic opportunity/ contributions (Pitkanen and Kouki, 2002: 110) and the societal incorporation of migrants (Groenendijk, 2001: 226, 234). The patient perspectives analyzed here suggest that admission to residence also has positive consequences for migrants' health outcomes and that prolonged insecure immigration status can be debilitating for both the resettlement seeker and the host society. This finding is consistent with research in other receiving societies concerning the adverse physical and mental health effects of such exile stressors as 'fears of being sent home' (Watters 2001: 1711; Sinnerbrink et al., 1997: 467) and the uncertainties and delays that surround the processing of asylum petitions (Carrington and Procter, 1995: 16; Silove, 2004: 92; Silove et al., 1997: 351, 353; 2000: 606).

Improved migrant health care advances population security (see Newman, 2003: 14–15). It reduces morbidity and mortality among those who traverse borders and their hosts, facilitates receiving-society acceptance, reinforces migrant resiliency (see Gozdziaik and Tuskan, 2000: 197–8, 202, 214–16; Watters, 1998: 285–6), and enhances opportunities for social adjustment, economic adaptation and political participation. The long-term consequences of failure to provide effective local health care for people in spatial transition include 'increasing prevalence of pathogens within a [receiving] state's population', diminished state capacity and augmented prospects for 'increasing proliferation of infectious disease within that society in a negative and self-reinforcing feedback loop' (Price-Smith, 2002: 173, 1–4).

Thus, policy measures that bring about greater equity in the treatment site characteristics encountered by asylum seekers are in the national interest of receiving countries. In light of the current and projected scarcity of ethnoculturally concordant and transnationally competent primary care physicians, one way that the goal of clinical context equity can be advanced is by changing reception policies so that they provide asylum seekers with

relevant information about available clinicians (Schmittiel et al., 1997: 1599) and with increased choice of principal attending GP. As House and Williams (2000: 108) observe, if disadvantaged groups 'do not have access to the same type and quality of providers and the same kind of relationships and communication with them as more advantaged persons, the result is likely to be their receiving less regular, preventive, and appropriate care'. Two approaches that promise to advance this key dimension of context equity are immediately available. The first would expand the pool of GPs that reception center residents could access while government authorities process their petitions for political asylum. An expanded pool to choose from could be achieved either by importing a larger and more transnationally competent cadre of GPs to work with patients in resettlement centers or by arranging for asylum seekers to access physician resources (see Le Feuvre, 2001: 133) at local public health sites on the same availability and financially subsidized bases as neighborhood residents. In either case, it is important that the enhanced pool consists of clinicians who are 'positioned and willing to play the advocate's role vigorously' and who can assist asylum seekers in accessing specialty care and other host society resources (Flaskerud, 1987: 156; Smedley et al., 2003: 185).

The second approach would focus on reducing the length of time involved in processing asylum applications in order to minimize the period during which asylum seekers are differentially cared for in a system that separates them from the rest of the population (Le Feuvre, 2001: 132). Two or more anxiety-filled years of role loss, dependency, uncertainty about one's future and (often) the 'medicalization' of social and structural barriers to wellness are unnecessarily punitive and debilitating (Miller, 1999: 284, 294). If immigration authorities processed asylum applications in a matter of a few months rather than years, then petitioners granted asylum could begin to address post-migration stressors sooner (Miller, 1999: 294, 298, 302; Silove and Ekblad, 2002: 402) and, without health-adverse delay, would be able to exercise the same range of choice over one's principal attending physician available to other legal residents. In promoting changes in asylum determination policy and implementation, health care personnel and social workers can join forces with NGOs such as Helsinki's Refugee Advice Center, which has characterized the normal one- to three-year waiting period as 'highly unacceptable' (cited in Kiuru, 2002: 17).

The situation of petitioners whose asylum applications are rejected also needs to be addressed. Presently, throughout Europe, many asylum seekers are denied legal residence, but few are deported. As Arthur Helton (2002: 169) points out, 'the dirty little secret in western European asylum practice is that while relatively few are granted refugee status, very few rejected asylum seekers are removed. Instead, their stay is "tolerated" and they subsist under uncertain circumstances without the possibility to integrate into society.' The context challenge presented here is that persons holding undocumented

status are not likely to be treated at all within the biomedical system until their condition reaches emergency proportions. Given the facility with which undocumented migrants cross national borders, this challenge requires an international burden-sharing policy approach. Although the study reported here did not encompass undocumented migrants, its findings suggest that uniform policy changes that would enable and encourage undocumented residents to secure medical care at community health centers as well as efforts such as the pan-European migrant-friendly hospital project (see [www.mfh-eu.net](http://www.mfh-eu.net)) would result in improved individual and societal health outcomes.

In the effort to improve global health, it is important that policy makers take the structural context of medical care into account. The findings of this comparative study of transnational medical encounters suggest that international and national health policy-makers and non-state actors who are concerned with strengthening global health need to be centrally engaged in ongoing debates over determinants of equitable local health care – including policies that affect grants of political asylum and access to community health care resources.

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#### NOTES

1. Most of those admitted as Ingrian Finns are descendants of 'Finns who in the 17th century settled in the lands around present day St Petersburg' (Korkiasaari and Soderling, 1998: 15) or of 'Finnish people who were incorporated into the Soviet Union at the end of the Second World War when part of the eastern district of Finland was annexed by the USSR' (Pitkanen and Kouki, 2002: 105; see also Forsander, 1999: 56–65, 70n).
2. By 2002, according to Institute of Migration figures, the number of native Somali speakers exceeded 7000 (also see Tiilikainen, 2003: 60). Fully 37 percent of the Somali speakers living in Finland in 2002 were under 10 years of age, as were 18–28 percent of the Vietnamese, Kurdish and Albanian speakers (Finland, Institute of Migration, 2003b).
3. Many arriving asylum seekers were Roma from Slovakia, Poland and the Czech Republic. Finnish authorities held arriving Roma briefly in reception centers, where they subjected their applications to accelerated review and, then, returned them to their 'safe countries' of departure or origin (Nordberg, 2004: 717–18, 727).
4. Assigning patients to doctors on the basis of the geographic location of their residence parallels the Swedish model, although 'recent [Swedish] reform initiatives have increased freedom of choice in some areas' (Freeman, 2000: 35). In many additional respects, moreover, the decentralized Finnish health care system resembles Swedish practice (see Freeman, 2000: 35, 37, 41–2, 105; Malin,

- 2000: 2; Lehto, 1999: 11–15). However, in contrast to the anecdotal evidence Freeman cites for Sweden (Freeman, 2000: 110), many of the foreign-born residents interviewed in this study changed doctors actively and rather frequently.
5. Juhani Lehto (1999: 10) points out that the detailed health instructions the center previously issued to local governments in Sweden and Finland have been relaxed in recent years and that central government subsidies are now issued as block grants.
  6. Sources in Joensuu were: the Mannerheim League for Child Welfare (providing a randomly sampled blind list of returning Finns and Russian-speaking spouses); Rantakyla District Health Center (randomly sampled lists of Russian-speaking and Vietnamese migrants); Rantakyla District social work office (a randomly sampled blind list of elderly returning Finns); and a Somali community leader's list of available adults. Of those contacted, only three refused to participate (two from the social work list and one from the Russian-speaking-migrants list). However, only one person out of the five selected from the Vietnamese migrant list showed up for an interview. One attending Joensuu physician (two cases) declined to be interviewed on grounds that he had moved to the health center of a different district. Two others (one case each) declined because they could not recall the patient.

Helsinki sources were: the Helsinki Foreigners' Crisis Prevention Center (a randomly sampled blind list of current clients); Herttoniemen Subdistrict Health Center (adult patients seen mid-June through mid-July 2002); the Association of Nigerians in Finland (available adult members who had seen a doctor and/or nurse); the Ingrian Center (available adult members who had seen a doctor and/or nurse); three Somali community leaders (available adults); and a Vietnamese community leader (available adults). There were no refusals reported among the selected foreign residents in Helsinki. Among all the sources approached, only the Rehabilitation Center for Victims of Torture proved uncooperative. The psychiatrist contracted by the Foreigners' Crisis Prevention Center (two cases) declined to be interviewed given the absence of monetary compensation. One other Helsinki physician (one case) said she was too busy to participate and one nurse (one case) refused.

Two migrants selected in Joensuu (one a 72-year-old returning male Finn and the other a male Somali) had to be dropped from the study because they had not seen a physician in Finland. In a handful of other cases, the doctor/dentist or nurse/dental assistant could not recall the patient or could not be sufficiently identified by the patient to be located.

7. For a full explanation and discussion of the items used to measure each dimension of TC in health care encounters, see Koehn (2004: 78–80).
8. In a few cases, we used statistical techniques designed to accommodate missing data when calculating mean TC scores.
9. The choice of cut-off points always is somewhat arbitrary (van Ryn and Burke, 2001: 816). The analysis reported here utilizes breaks where at least 20 percent of each group fit in the high-TC category and at least 15 percent fit in the least-TC category.
10. Three of the five reception centers included in this study are located a considerable distance from the city center in a relatively isolated setting. Only the reception centers in Helsinki and Kotka are centrally located. However, all reception centers are 'open', in that asylum seekers are allowed to move freely within the wider Finnish society.

11. It is important to recognize, however, that many South to North migrants possess their own transnational social networks. In the case of Kurdish refugees, for instance, Osten Wahlbeck (1999: 2, 84, 145–7) found that ‘almost immediately upon arrival in Finland the refugees were able to get in touch with compatriots, friends and relatives in Finland, Europe and Kurdistan’. With respect to Vietnamese resettlers, see Valtonen (1996: 476, 478, 486).
12. At least one clinician reported for 85 cases, yielding intersubjective data on 91 percent of the 93 medical encounters sampled.
13. For an illustration of provider functional competence in a clinical setting involving encounters with refugees from multiple national backgrounds, see Derges and Henderson (2003: 94).
14. An example of an especially helpful booklet that could be translated into languages other than Finnish and English is Hille Puusaari’s (n.d.) *Settling Down in Finland: A Guide for the Immigrant*.
15. This finding is based on cross-sectional data. Longitudinal studies that assess the long-term health effects of protracted asylum-seeking status are needed.

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## RÉSUMÉ

*Migration Transnationale, Politique Nationale et Traitement Professionnelle de la Santé pour les Chercheurs d'Asile et Ressortissants Nés à l'Étranger: Perspectives Comparatives du Centre d'Accueil et Pratiques de Soins de Santé pour la Communauté en Finlande*

Fondé sur des entretiens dans cinq centres d'accueil et deux communes municipales pendant l'été de 2002 avec 93 migrants, originaires surtout de pays du Sud et de l'Est, ainsi qu'avec leurs médecins d'une ethno-culturalité dissonante, cet article fait une comparaison entre les chercheurs d'asile et les résidents nés à l'étranger en ce qui concerne le traitement de la santé et les résultats attendus. L'analyse comparative suggère que le contexte fait une différence lors d'entretiens médicaux après la migration. Les étrangers admis régulièrement qui ont demandé de soins de santé auprès de centres de santé de la communauté avaient une plus grande possibilité d'être satisfaits avec les soins reçus, par comparaison avec ceux ayant reçu des soins aux centres d'accueil, ainsi que de faire confiance aux recommandations du médecin en cas de besoin dans le futur. On explore dans ce document les implications tirées de cette étude pour la formulation de politiques. En Finlande et ailleurs il semble avoir besoin de repenser la formation générale de médecins généralistes pour ces contacts internationaux. Les efforts nationaux et internationaux pour améliorer la condition de la santé doivent aussi inclure les mesures d'asile politique et de relocation dans le Tiers Monde. En Finlande ainsi que dans d'autres pays accueillant des migrants, la condition d'insécurité prolongée liée au statut d'immigration peut être un facteur d'affaiblissement pour le ressortissant étranger aussi bien que pour la société d'accueil. Les procédures d'admission à la résidence régulière et un choix de médecins plus élargie peuvent donner lieux à des meilleurs résultats dans la santé.

## RESUMEN

*Migración Transnacional, Política Nacional y Tratamiento por Profesionales de Salud Locales para Solicitantes de Asilo y Residentes Nacidos en el Extranjero: Perspectivas Comparativas del Centro de Recepción y Prácticas de Atención Médica para la Comunidad en Finlandia*

El artículo compara la atención de salud para los solicitantes de asilo y los residentes nacidos en el extranjero y los posibles resultados basándose en las entrevistas realizadas en cinco centros de recepción y dos comunas municipales en Finlandia durante el verano del 2002 a 93 inmigrantes, principalmente provenientes de países del Sur y del Este, y a los profesionales de salud locales que provienen de contextos étnicos y culturales diferentes. Los análisis comparativos sugieren que el contexto es un factor de diferenciación en las consultas médicas posteriores a la inmigración. Los ciudadanos extranjeros legalmente admitidos que recibieron atención médica en las instalaciones comunitarias de atención presentan mayores posibilidades de estar

satisfechos y se muestran más confiados en que las recomendaciones del médico que los atendió les serán de gran utilidad en el futuro en comparación con los solicitantes de asilo entrevistados en los centros de recepción. Se exploran las implicaciones de los resultados de este estudio para la formulación de políticas. Se necesita mejorar la formación de los profesionales en para que den atención médica en situaciones que involucran diferentes nacionalidades en en Finlandia y otros lugares. Los esfuerzos nacionales e internacionales para promocionar la salud también deben abarcar las políticas de asilo político y reubicación en países del Tercer Mundo. En Finlandia y en otros países que reciben inmigrantes, la inseguridad en la condición de inmigrante puede debilitar tanto al solicitante de asilo como a la sociedad que lo acoge. Es probable que con procesos de admisión más rápidos para obtener la residencia legal y un mayor número de médicos disponibles se mejore los resultados en la salud.

#### BIOGRAPHICAL NOTE

PETER H. KOEHN is Professor of Political Science at the University of Montana – Missoula. He is a member of the inaugural class of Fulbright New Century Scholars and author of *Refugees from Revolution: U.S. Policy and Third-World Migration* (Westview, 1991). He has taught at universities in Ethiopia, Nigeria, Namibia, China and Hong Kong. His recent publications include 'Medical Encounters in Finnish Reception Centres: Asylum-seeker and Clinician Perspectives', *Journal of Refugee Studies* 18(1, 2005): 47–75; 'Transnational Competence in an Emergent Epoch', a vision of international studies piece co-authored with James N. Rosenau, *International Studies Perspectives* 3 (May 2002): 105–27; *Organizational Communication in Refugee-Camp Situations* (United Nations High Commission for Refugees, 2002), co-authored with Phyllis B. Ngai; and *The Expanding Roles of Chinese Americans in US-China Relations: Transnational Networks and Trans-Pacific Interactions* (M.E. Sharpe, 2002), co-edited with Xiao-huang Yin. He collected the data upon which this article is based as part of a research project conducted while a visiting scholar at the University of Joensuu's Center for Ethnic Studies (ETNICA). In December 2004, he delivered an invited plenary address on 'Enhancing Migrant Competence in Transnational Health-Care Encounters' at the international conference 'Hospitals in a Culturally Diverse Europe' held in Amsterdam. He is the University of Montana's Distinguished Scholar for 2005. Please address correspondence to: Peter H. Koehn, Professor of Political Science, University of Montana, Missoula, Montana, 59812, USA.  
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